

**daratumumab-hyaluronidase
1800 mg -
cyclophosphamide 300 -
bortezomib 1.5 -
dexamethasone 20 mg**

Regimen: Cycle 1 (Part I)

ARIA Protocol Name: Daratumumab SC CyBorD (age and comorbidities)

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma

Name: _____

HCN: _____

Date of Birth: _____



CC4200 0231 08 2022

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle of **Cycle Duration: 28 days**

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1 X 10⁹/L and platelets **greater than or equal to** 80 X 10⁹/L, otherwise notify Hematologist
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment completed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- allopurinol 300 mg PO** on day 1
- 60 minutes prior to daratumumab-hyaluronidase: dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on day 1
- 60 minutes prior to daratumumab-hyaluronidase: diphenhydrAMINE 50 mg PO** on day 1, 8, 15 and 22
- 60 minutes prior to daratumumab-hyaluronidase: acetaminophen 650 mg PO** on day 1, 8, 15 and 22
- 60 minutes prior to daratumumab-hyaluronidase: montelukast 10 mg PO** on day 1
- Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- allopurinol 300 mg PO** once daily on days 2 to 5
- acyclovir 800 mg PO** once daily until one month post completion of daratumumab/bortezomib treatment
- metoclopramide 10-20 mg PO** every 4 hours as needed
- Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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Doctor's Order Sheet

**daratumumab-hyaluronidase
1800 mg -
cyclophosphamide 300 -
bortezomib 1.5 -**

dexamethasone 20 mg Regimen: Cycle 1 (Part II)
ARIA Protocol Name: Daratumumab SC CyBorD (age and comorbidities)

Adult Chemotherapy - Hematology Oncology

Multiple Myeloma



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Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- cyclophosphamide 300 mg/m² X BSA = _____ mg**
 - Dose modification: **cyclophosphamide 300 mg/m² X BSA - _____ % = _____ mg**

PO on day 1
- bortezomib 1.5 mg/m² X BSA = _____ mg**
 - Dose modification: **bortezomib 1.5 mg/m² X BSA - _____ % = _____ mg**

SC on day 1, 8, 15 and 22
- daratumumab-hyaluronidase 1800 mg**

SC on day 1, 8, 15 and 22

Administer over 3 to 5 minutes into abdomen

First injection: Observe patient for 4 hours after daratumumab-hyaluronidase SC injection

Subsequent injections: If no reaction in previous injection, observe patient for 15 to 20 minutes after daratumumab-hyaluronidase SC injection

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- dexamethasone 8 mg PO** once daily in the morning on day 2, 9, 16 and 23
- dexamethasone 20 mg PO** 60 minutes pre daratumumab-hyaluronidase on day 8, 15 and 22
- cyclophosphamide 300 mg/m² X BSA = _____ mg**
 - Dose modification: **cyclophosphamide 300 mg/m² X BSA - _____ % = _____ mg**

PO on day 8, 15 and 22

This prescription is NOT eligible for medication management by a pharmacist

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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